



Pediatric Clinic, P.A.

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PATIENT	First	Middle	Last	Nickname (if any)	Present Age	Date of Birth	
	Mailing Address			Social Security #	<input type="checkbox"/> Male <input type="checkbox"/> Female	Primary Phone Number	
	City / State / Zip			Preferred Language: English Spanish Other	Race: White Black / African American American Indian Asian Native Hawaiian/Pacific Islander Ethnicity: Hispanic/Latino Non-Hispanic/Non-Latino Other or Undetermined		
PARENT/GUARDIAN	Mother's Name			Date of Birth	Primary Phone	Home Work Cell	
	Address (if different)		Social Security #	Driver's License#	Alternate Phone	Home Work Cell	
	Employer			Email Address			
	Father's Name			Date of Birth	Primary Phone	Home Work Cell	
	Address (if different)		Social Security #	Driver's License #	Alternate Phone	Home Work Cell	
	Employer			Email Address			
	Responsible Party (if parent under 18 years of age/Foster parent/Guardian)		Relationship	Date of Birth	Primary Phone	Home Work Cell	
	Address (if different)		Social Security #	Driver's License #	Alternate Phone	Home Work Cell	
	Employer			Email Address			
	INSURANCE	Patient's Primary Insurance Company		Name of Insured Party	Insured Date of Birth	Insured Phone	
		Insured Party Social Security #	Insured ID #	Policy Group #	Relationship to patient		
		Patient's Secondary Insurance Company		Name of Insured Party	Insured Date of Birth	Insured Phone	
Insured Party Social Security #		Insured ID #	Policy Group #	Relationship to patient			
EMERGENCY CONTACTS	Name		Phone	SIBLINGS	Name		Date of Birth
	Name		Phone		Name		Date of Birth
	Name		Phone		Name		Date of Birth
	Name		Phone		Name		Date of Birth

Signature of Responsible Party _____ Date _____

Update Signature _____ Date _____

Update Signature _____ Date _____

Update Signature _____ Date _____



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PARENTAL CONSENT FOR TREATMENT

In accordance with Texas Law, the Pediatric Clinic will not provide health care to minors unless a parent accompanies them, a parent provides written consent, or a way is provided for the clinic to contact the parent.

In Texas, a patient is considered a “minor” if he/she is under 18 years, has never married, or has not been declared a legally emancipated minor.

I authorize the following individuals to seek medical treatment for the following child in my absence.

Patient/Child

Patient/Child Date of Birth

Name of Individual/Relationship

Phone #

Name of Individual/Relationship

Phone #

Name of Individual/Relationship

Phone #

Name of Individual/Relationship

Phone #

Parent/Legal Guardian

Date